DEPARTMENT OF THE ARMY
WALTER REED ARMY MEDICAL CENTER
6900 GEORGIA AVENUE, N.W.
WASHINGTON, DC 20307

WRAMC Pamphlet
No. 608-19

26 March 2002

Personal Affairs

MANAGEMENT OF ALLEGED CHILD/SPOUSE/ELDER ABUSE OR NEGLECT CASES

1. HISTORY. This document combines the existing documents that address management of abuse and neglect cases. The quality of family life has a direct bearing on the soldier's job performance and ultimately affects the morale, discipline and health of the Command. Walter Reed Army Medical Center (WRAMC) has a Family Advocacy Program (FAP) to provide assistance to child, spouse, and elderly victims of maltreatment. Delay in reporting can and does often lead to re-injury and in some cases even death.

2. APPLICABILITY. This policy applies to all personnel responsible for providing health care within Walter Reed Army Medical Center.

3. PURPOSE. This regulation provides guidelines for identifying, reporting, and evaluating maltreatment of children, spouses and the elderly at Walter Reed Army Medical Center and the outlying health clinics.

4. REFERENCES.

a. DOD Directive 6400.1, Family Advocacy Program, 23 Jul 1996.

b. DOD Instruction 6400.2, Child and Spouse Abuse Report, 10 Jul 1987.

c. AR 608-18, The Army Family Advocacy Program, 1 Sep 1995.

d. MEDCOM Pamphlet 608-1, Family Advocacy Program, 2 Mar 1998, Change 5, 11 Jun 2001.

e. WRAMC Pamphlet 608-18, Family Advocacy Program, 18 Oct 2001.

5. EXPLANATION OF ABBREVIATIONS AND TERMS. Abbreviations and special terms used in this publication are explained in the glossary and Appendix A (Criteria for Identification of Suspected Victims of Maltreatment).

6. POLICIES. To aid in gathering information necessary to determine immediate safety of victims, every individual who presents for medical care as a result of suspected/alleged abuse or neglect will be assessed according to the procedures outlined in this document.

7. REFERRAL AND REPORTING PROCEDURES.

a. The Department of Social Work (DSW) is the designated Reporting Point of Contact (RPOC) for Walter Reed Army Medical Center. All allegations of maltreatment will be immediately reported to the Walter Reed community RPOC.

b. During duty hours, referrals should be coordinated directly with the Department of Social Work team that supports the health clinic where the family receives their medical care. After duty hours, the on-call social work provider can be reached by the Walter Reed Army Medical Center Administrative Officer of the Day (AOD) or the Provost Marshal's Office (PMO) for reports of maltreatment.

c. The Department of Social Work will contact the appropriate Law Enforcement agencies, Department of Social Services (DSS), Command, and conduct an evaluation (risk assessment) as appropriate.

d. The WRAMC DSW serves as liaison to the outlying community SW clinics when beneficiaries from their respective clinics, who have been maltreated, present to the WRAMC Department of Emergency and Operational Medicine (DEOM) for care.

8. RELEASE OF MEDICAL INFORMATION. The only personnel authorized to release medical information is the Patient Administration Division (PAD). PAD may release a certified copy of the record but will never release original documents. All requests for records should be made in writing on a DA Form 4254-R and forwarded to PAD. If PAD is not available, contact the WRAMC Center Judge Advocate (CJA) office for guidance. There are few situations that warrant immediate release of medical information to law enforcement authorities. In emergency situations (rape, child abuse, or death), where the need for the information may be urgent, both the request for information and permission for disclosing it may be given verbally by PAD. As soon as possible, PAD will follow up the verbal request with a written request on DA Form 4254-R.

9. RESPONSIBILITIES.

a. Health Care Providers will:

(1) Know the criteria for suspected abuse and neglect as outlined in **Appendix A** and refer any patient who is a suspected victim of physical abuse, sexual abuse, or neglect to the RPOC. Cases requiring assessment after duty hours are brought to the DEOM where the responsibilities listed in paragraphs b through d apply.

(2) Provide requested medical examination and documentation in their area of expertise on a same-day basis in non-emergency cases.

(3) Notify the on-call social worker so that before the patient/family leaves the clinic a risk assessment has been conducted and a safety plan established.

(4) Notify and consult the pediatrician on-call for child maltreatment cases. At a minimum, initiate telephonic consultation regarding evaluation and treatment.

(5) Obtain a history of injury/abuse from the patient/victim. The patient/victim will be separated from the alleged offender. Under no circumstances, will the alleged offender be left alone with the patient/victim.

(6) Determine the need for hospitalization for medical or safety reasons and the need for involuntary foster care placement as an option. A child may be placed into medical protective custody, without parental consent, if returning custody of the child to the parents would present imminent danger to the child's life or health (AR 608-18, Para. 3-26).

The physician, in conjunction with the social worker and law enforcement, determine the need for involuntary placement and make this recommendation to the Medical Center Commander in consultation with the Center Judge Advocate. If the decision is made to place the child in medical protective custody, WRAMC Form 1376, Medical Protective Custody of Child **(Appendix C)** will be completed and signed by the hospital commander. The Provost Marshall may assist with parents who refuse to allow the child to be hospitalized. Emergency hospitalization will be for a "reasonable" period of time, until a court order may be obtained.

(7) Order additional tests and procedures as indicated. A full body x-ray examination (skeletal survey, to include long bones, skull series, and chest x-rays), bone scan, complete blood count, and urinalysis should be done on any child under one year of age with any suspicious skeletal fracture or unusual soft tissue injury.

(8) Collect, maintain, safeguard information and evidentiary materials to be used in legal proceedings.

(9) Notify and document notification of law enforcement officials (PMO, CID, OSI) in the medical record in cases of suspected rape and injuries.

(10) Document the release of information to law enforcement officials and legal authorities in the medical record.

(11) Protocol for Child Abuse and Neglect (PCAN) **(Appendix B)** will be completed on all child cases by the attending physician. When appropriate, MEDCOM OP Form 6-R, Child Abuse and Neglect Physical Exam, or MEDCOM OP Form 33-R, Spouse/Elder Abuse Checklist **(Appendix D)** will be completed and provided to the social worker. One copy of the DEOM documentation will be immediately released to Department of Social Work.

(12) Photograph visible findings with color film. Ask the Photographer to bring Form 28, Medical Illustration Service Request and Release. The photographer can be reached at 782-7074 during duty hours. After duty hours call the Administrative Officer of the Day (AOD) at 782-7309 who will contact the photographer.

(13) Ensure Department of Social Work has coordinated a safety plan and follow-up service(s), prior to Medical Center discharge.

(14) Refer patients to the appropriate clinic for follow-up medical care.

b. The DEOM Charge Nurse will complete the following actions anytime alleged/suspected victims of abuse/neglect are seen:

(1) Notify the following:

(a) Provost Marshall (Desk Sergeant).

(b) The DEOM Physician in Charge.

(c) The DSW on-call social worker.

(d) Pediatrician on-call (cases of child maltreatment).

(2) Before arrival of on-call social worker, the charge nurse will:

(a) Take the patient to the first available exam room in the DEOM, take vital signs and triage the patient. All suspected/alleged victims of abuse/neglect will be triaged at least as urgent.

(b) Appoint one hospital staff member to remain with the victim until the arrival of the on-call social worker (and afterwards, if the victim requests).

(c) Under no circumstances allow the alleged/suspected offender of the abuse/neglect to be left alone with the patient until the case is transferred to the on-call social worker and/or the CID investigator.

c. The DEOM physician will:

(1) Obtain and record a pertinent medical history and perform a total body examination for evidence of trauma.

(2) Give emergency medical support and treatment as indicated, coordinate with the on-call social worker in the assessment of the victim's current emotional status, and determine if there is a medical contraindication to an interview by CID investigators.

(3) Consult with other on-call physicians, as indicated by the age and/or circumstances of the alleged/suspected abuse/neglect. **Pediatricians will be consulted, at least telephonically, in all child sexual abuse cases**.

(4) Ensure that the proper chain of custody for any collected evidence is established. Collected evidence must be retained in physical custody of the examining physician until turned over to law enforcement authorities.

(5) Parental Consent: The DEOM physician should be mindful of the following: " Unless otherwise required by applicable law, parental consent is not required for medical examination, treatment, or hospitalization of a victim of child abuse in the MTF when one or both of the parents are suspected of inflicting the abuse or in concealing information about the abuse." (Para 3-19b, AR 608-18).

d. Family Advocacy Program (FAP) social worker will (during normal duty hours):

(1) Conduct an initial risk assessment. The assessment will consider the patient situation and the potential need for court involvement, foster care or emergency shelter when developing a safety plan.

(2) Collect, maintain, safeguard information/material obtained from victims of abuse and document social work intervention in the social work case file.

(3) Notify law enforcement personnel of suspected maltreatment within 24 hours of initial notification, and coordinate with CID for joint interviews with individuals involved in the case as indicated.

(4) Advise the attending physician about the risk assessment and plan of action. This will be accomplished in person if warranted, or through use of Consultation Form, SF 513, Composite Health Care System (CHCS), or by telephone.

(5) Notify Chain of Command of suspected maltreatment within 24 hours of initial contact and coordinate safety plan.

(6) Notify civilian DSS of suspected maltreatment within 24 hours of initial contact and coordinate safety plan.

(7) Monitor cases after discharge from hospital/MTF in order to assess caregiver compliance with treatment plan and reassess patient safety.

(8) Upon request and if appropriate, provide information to the court system or to the patient for rulings in a case.

(9) Refer victims and offenders with emotional or behavioral disorders for outpatient counseling as indicated.

(10) Refer victims and offenders with drug and alcohol issues to the Army Substance Abuse Program (ASAP) as indicated.

(11) Educate command on the FAP and Case Review Committee (CRC) process. Invite command to the CRC meeting.

(12) Contact the assigned DSS worker for collaboration on the assessment and treatment of the mutual client.

(13) Maintain a list of public and private community agencies for victims of abuse.

e. The DSW On-Call Social Worker will (after duty hours and on weekends/holidays):

(1) Document the incident, complete the risk assessment ensuring the immediate safety/protection of the alleged/suspected victim utilizing community resources as necessary.

(2) Ascertain that the patient has been informed of his or her rights.

(3) Coordinate community resources as indicated (i.e. providing requested information, unit/family notification, foster care, safe haven, etc.).

(4) Remain with the victim during the medical examination (per the victim's request or as indicated) and the interview by CID investigators, as appropriate.

(5) Coordinate with the consulting physician on the patient's emotional condition, if indicated.

(6) Notify law enforcement personnel of suspected maltreatment within 24 hours of initial notification, and coordinate with CID for joint interviews with individuals involved in the case as indicated.

(7) Notify Chain of Command of suspected maltreatment within 24 hours of initial contact and coordinate safety plan.

(8) Notify DSS of suspected maltreatment within 24 hours of initial contact and coordinate safety plan.

(9) Refer cases to the DSW, Chief of Family Advocacy the first duty day following the report for follow-up.

f. Chief, Department of Social Work will:

(1) Provide an on call roster to AOD, ER and PMO for a social work provider to be available during non-duty hours.

(2) Ensure referred patients are properly evaluated and appropriate crisis intervention techniques are used.

(3) Provide follow-up care or referral as needed for each referred patient. If there is evidence of child/spouse abuse or neglect, Department of Social Work will present the case to the CRC in accordance with the provisions of AR 608-18.

(4) Coordinate with the Chief, Department of Primary Care to ensure that the Medical Officer of the Day and DEOM staff are familiar with local FAP policies and procedures.

g. Army Community Services FAP Manager will provide training to all hospital personnel on identification and reporting procedures during newcomer's briefings, annual BMAR training and through Nursing Education Division as scheduled by the training coordinator.

Appendix A

CRITERIA FOR IDENTIFICATION OF SUSPECTED VICTIMS OF MALTREATMENT

1. CHILD PHYSICAL ABUSE

Definition: Non-accidental injury to a child under the age of 18 by a parent or caretaker.

a. INDICATORS OF PHYSICAL ABUSE

(1) Bruises, burns, bite marks, head or bone injuries without adequate explanation.

(2) Bruising or red marks on the skin in the shape of a belt, hand, rope or blunt instrument.

(3) Burn injuries from immersion in hot water may be seen on the hands or buttocks, leaving a doughnut shaped configuration on the buttocks, or glove like burn marks on hands or feet.

(4) Contact burns will conform to the shape of the device used (cigarette, iron, curling iron, burner).

(5) Bite marks on the child's body.

(6) Fractured bones in multiple stages of healing.

(7) Shaken baby syndrome (usually no visible signs. Children under two are most prone due to size of head compared to body and weak neck muscles).

(8) Delay in seeking medical care for injury(s).

(9) Discrepancies or contradictions in the explanation on mechanism of injury.

(10) Injury is inconsistent with developmental age of the child.

(11) Unexplained death.

b. RISK FACTORS

(1) Parental/family stress (deployments, alcoholism, financial stress, illness).

(2) Parental childhood history of abuse.

(3) Physical, mental or psychosocial disorders in a child (hyperactivity, mental retardation, behavioral disorders, emotional problems) which may predispose them to abuse.

Appendix A (Continued)

c. HEALTH CARE PROVIDER ROLE

(1) Document as much information about the injury as possible; appearance, configuration, location, dating, plausibility.

(2) Collect information from the parents about the cause of the injuries.

(3) Contact Department of Social Work, the Reporting Point of Contact (RPOC).

(4) The injury should be photographed by the hospital photographer. The photographer can be reached at 782-7074 during duty hours. After duty hours call (202) 991-4535, after the ring and tone, dial call back number OR call the AOD who will contact the photographer.

(5) If the DSW social work provider is not present, contact PMO/CID.

2. CHILD NEGLECT

Definition: Failure of a parent or caretaker to provide for a child's basic needs for food, clothing, shelter or medical care.

a. INDICATORS OF CHILD NEGLECT

(1) Parents not seeking medical/dental care for the child.

(2) Child unsupervised for extended periods of time.

(3) Failure to thrive (lack of nurturing, holding, cuddling and infant stimulation).

(4) Child residing in an unsafe home due to environmental conditions.

(5) Inadequate food, clothing, shelter.

b. HEALTH CARE PROVIDER ROLE

(1) Teach parents about the needs of children. Some parents may inadvertently neglect a child due to lack of education and/or skills in providing a safe home environment.

(2) Refer suspected neglect, whether acute or chronic, to Department of Social Work for complete assessment.

3. CHILD SEXUAL ABUSE

Definition: Any sexual activity between an adult and child, or sexual exploitation of a child for gratification or profit.

a. INDICATORS OF POSSIBLE CHILD SEXUAL ABUSE

Appendix A (Continued)

(1) Indirect or direct statements and/or behaviors (i.e., during play) of a sexual nature which indicate sexual knowledge beyond their age level.

(2) Direct statements made by a child to indicate sexual abuse.

(3) A constellation of behavioral changes.

(a) Sleeping and eating disturbance.

(b) Acute reactions (fear, phobias, clinging, anger, tantrums).

(c) Depression, suicide attempts.

(d) Runaway behavior and poor conduct.

(e) Conversion reactions.

(f) Sexual behavior inappropriate for age.

(g) Poor school performance.

(h) Unusual or change with toileting habits.

b. ROLE OF THE HEALTH CARE PROVIDER

(1) Contact Department of Social Work, the RPOC, who will coordinate the interview of the child/family with Child Protection Services (CPS) and CID.

(2) A pediatrician will conduct examination of the child.

4. SPOUSE ABUSE

Definition: Physical, emotional, or sexual maltreatment ranging from pushing, shoving, hair pulling, belittling, and acts of violence against the spouse resulting in serious injury/death.

a. CRITERIA FOR IDENTIFYING VICTIMS OF SPOUSE ABUSE.

(1) The spouse may present for medical treatment offering inconsistent or nonviable explanations for injuries.

(2) Offender may accompany victim, and present as loving and affectionate toward the victim who may reciprocate (this is the honeymoon phase that follows the episode of violence).

(3) The victim presenting for examination may be tearful and apprehensive of the health care team. The victim may also be protective of the abuser and defend his or her actions.

(4) Typically, the spouse will sustain repeated unexplained injuries; a pattern may become evident with review of the medical record.

(5) Male victims usually present after more severe injuries such as knife wounds, lacerations to the head, or gunshot wounds.

b. RISK FACTORS

(1) There are no known risk factors/characteristics of victims of spouse abuse, however, the following are frequently true:

(a) A pattern of violence, dating back to courtship/early marriage.

(b) Mutual spouse abuse.

(c) Poor anger control in one or both spouses.

(d) Childhood exposure to family violence and/or neglect.

(e) Alcohol usage.

c. ROLE OF THE HEALTH CARE PROVIDER

(1) Contact Department of Social Work, the RPOC, who will conduct an assessment and make the mandatory notifications.

(2) Support the victim. Encourage him/her to consider his/her safety before returning to the home.

(3) If possible, separate the couple until Department of Social Work can evaluate them.

5. ELDER ABUSE/NEGLECT

Definition: Injury or neglect of an elderly person caused by a family member or caregiver. Neglect occurs more commonly than physical or sexual abuse.

a. INDICATORS OF ELDER ABUSE/NEGLECT

(1) Malnutrition, dehydration, pressure ulcers, urine burn excoriations, bilateral bruises imprint injuries, and rope burns.

(2) The victim may seem fearful or apprehensive.

(3) Common themes may include allegations that the caregiver is taking money or using coercion to access victim's finances.

(4) Misuse of the elderly patient's medication (over medication, etc.).

(5) Caregiver may express frustration or exasperation over care taking responsibilities.

b. ROLE OF THE HEALTH CARE PROVIDER

Appendix A (Continued)

(1) Contact Department of Social Work, the RPOC, who will conduct an assessment and make the mandatory notifications including Adult Protective Services (APS) if necessary.

(2) Listen to what the elderly patient has to say. Determine whether reports of being mistreated/neglected are consistent with mental status or other factors.

(3) Do not dismiss too quickly direct statements made by the victim as senility or dementia.

(4) Review admissions for over-medication, under-medication, and inadequate nutrition as these are signs that the patient may not be receiving adequate care and should be evaluated for neglect. Take advantage of all opportunities to educate family members on caring for the elderly parent or family member.

Appendix B

Physician Protocol for Evaluation of Non-Accidental Trauma (NAT) and/or Physical Neglect of Children

PROCEDURES:

1. Report all suspected maltreatment to the WRAMC Department of Social Work (DSW). The DSW will report to the appropriate county Child Protective Service unit and the WRAMC Provost Marshall (782-7511/12). The DSW can be reached:

a. At 782-6378 during duty hours (0730-1630).

b. After duty hours, weekends and holidays, through the Administrative Officer of the Day (AOD) at 782-7309. The AOD will page the on-call social worker.

2. Coordinate conducting the medical evaluation with the WRAMC Social Worker involved in the case as necessary. Jointly decide how to handle hostile or volatile caretakers/parents. The Provost Marshall's are available to assist with difficult situations.

3. Obtain a detailed history of the injury from the child with the parents absent. Then obtain a history of injury from the parent or caretaker with the child out of the room and corroborate the findings. MAINTAIN A HIGH INDEX OF SUSPICION!

4. Prepare the child for the emotional aspects of the physical examination, especially in cases of alleged sexual abuse.

5. Perform a thorough physical examination. Parental consent to photograph injuries is not required.

a. Consider a long bone X-ray examination on all possible NAT children younger than two years old. Consider laboratory studies if within 24 hours of injury/incident, or if clinically indicated.

b. Photograph visible physical findings with color film. Ask the photographer to bring Form 28, Medical Illustration Service Request and Release. The physician must fill our Form 28. Parental permission is not required. The photographer can be reached at 782-7074 during duty hours. After duty hours, call (202) 991-4535, after the ring and tone, dial call back number OR call the AOD who will contact the photographer.

c. Record all physical findings using the Child Abuse and Neglect Physical Exam form, MEDCOM OP 6-R, (MCHO) Jul 95.

6. Record how soon medical care was sought after the injury was discovered; comment on whether explanations of the injury are consistent, whether explanation of the injury is plausible, and whether findings are consistent or inconsistent with type of alleged maltreatment. **Do Not record the opinion that abuse/neglect definitively did or did not occur.**

Appendix B (Continued)

7. Coordinate with the DSW to determine whether returning the child to the caretakers/parents presents imminent danger to the child. If medical custody is warranted based on the Risk Assessment (completed by the Social Worker) and the professional opinion of the treating physician – follow the steps in paragraph 7a below.

a. Medical Protective Custody (MPC). The physician will:

(1) Chart the decision to implement MPC and why.

(2) Complete the Medical Protective Custody form (see enclosure D). Date the form, which is effective for only 24 hours. Ensure the Center Judge Advocate (JAG) has been consulted before the MPC is sent to the Commander. During duty hours the Center Staff Judge Advocate can be reached at 782-7531. After duty hours call the AOD and ask that the JAG representative be contacted.

(3) Forward the MPC form to WRAMC Commander for signature. The AOD can sign for the commander after duty hours and with consultation with the JAG.

(4) Try to obtain consent from the parents to hospitalize the child. Explain the provisional diagnosis (non-accidental trauma), and the legal and Army regulation requirements to report the injury and take all measures to keep the child safe.

(5) Take all prudent actions to prevent removal of the child until WRAMC commander and/or civilian court rules. The WRAMC Provost Marshall (782-7511/12) can assist to prevent removal.

(6) Visitation to the child by the caretakers/parents is determined by the physician in consultation with the social worker involved in the case and the JAG.

(7) Inform the WRAMC inpatient pediatric nursing service of the circumstances of the child's hospitalization and guidelines for visitation.

(8) Prior to discharge or release of the child contact DSW Family Advocacy Program (FAP). Coordinate with DSW FAP representative as the case progresses, as needed.

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TO: _____ DATE: _____

SUBJECT: Child Abuse/Neglect Evaluation Process Advisement

1. Because of the nature/severity/circumstances of your child's injuries, your child _____ is being evaluated for possible child abuse or child neglect. This letter is to inform you of the reasons for this evaluation, your rights during this evaluation, the expected course of the evaluation, and requirements that have been incorporated in this evaluation designed to protect your reputation.

2. All states, territories, and the District of Columbia, requires that any health care provider (doctor, dentist, nurse, corpsman, etc.) report any suspicion of child abuse or child neglect. They have no discretion and must report. Failure to report is an unlawful act that may be punished by civil or criminal penalties. To facilitate evaluation, a standardized procedure has been developed that assures complete and fair evaluation of the case. Each case can then be thoroughly reviewed to determine if child abuse or child neglect did occur. The people conducting the review have experience in this area and are interested in finding the truth, not in ruining reputations or causing unnecessary distress to a family.

3. We want all children to grow and develop under the best possible circumstances. so while we ask your cooperation, at the same time we understand any feelings of hurt, anger, frustration, and defiance that you may feel. It is hoped that you will cooperate, and feel free to ask any questions that you may have. If you feel you cannot communicate with the person doing the initial evaluation, please feel free to ask for someone else to talk to.

4. Your rights will be protected throughout the evaluation. You have the same rights any citizen. Most reports of suspected child abuse or child neglect are proven to be invalid. However, because some cases are valid and may require legal action, in all cases the parents may exercise the legal rights guaranteed by the U.S. Constitution. The rights are as follows:

a. You do not have to answer any questions or say anything. Further, anything you say or do can be used as evidence against you in a civil or criminal trial.

b. If you are subject to the Uniform Code of Military Justice, you have a right to talk to a lawyer before or after questioning, or have a lawyer present with you during questioning. This lawyer can be a civilian lawyer of your own choice at your own expense, or a military lawyer detailed for you at no expense to you. Also, you may ask for a military lawyer of your own choice by name, and he will be detailed for you if his superiors determine he is reasonably available.

c. If you are a civilian, not subject to the Uniform Code of Military Justice, you have a right to talk to a lawyer before or after questioning, or have a lawyer present during questioning. You are also advised that if you are a military dependent, you may wish to consult a legal assistance officer, if available.

d. If you are willing to discuss the injury or medical problem of your child, with or without a lawyer present, you have a right to stop answering questions at any time or speak to a lawyer before answering further.

5. Additionally, you have the right to have your child examined by other physicians or health care providers to obtain an additional opinion. These may be either military or civilian. Be advised that if you choose to have your child examined by a civilian, you will be responsible for any fee.

6. Every effort will be made to provide you information on the status of the case upon your request.

7. Certain other matters are important for you to know:

a. Laws in all states grant immunity from liability for anyone who reports a case of child abuse or child neglect in good faith.

b. State laws in all states grant anonymity protection to anyone reporting child abuse or child neglect. You may not obtain the name of a person reporting you unless they grant release of this information.

c. Many states permit health care providers to x-ray, photograph, or admit a child to a hospital without parental permission. If you are in such a state, you may not block these actions.

8. In evaluations of possible child abuse or child neglect, a standard procedure is followed. Initial data is collected either by the health care provider who makes initial contact, by a physician on duty during off duty hours, or by a pediatrician or other physician designated to handle such cases during duty hours. A thorough history and physical examination will be performed. A social evaluation will be performed by a medical social worker or other designated personnel. Home visits may be made by Community

Health Nurses and/or civilian social workers who work for the state child welfare office. A family advocacy case management team (FACMT) then collects and evaluates all data. They determine if a case is substantiated, unsubstantiated, or suspected. If established they make a plan for working with the family. If unfounded they close the case. If there is any question, they usually monitor the family for a period of time. Further, in most states child welfare agencies may institute investigations which result in criminal and/or civil court proceedings if appropriate. You may wish to consult with legal counsel on your rights and responsibilities regarding a state investigation of alleged child abuse and/or neglect.

9. In all cases, every effort will be made to keep you informed as to how your case is progressing and what decisions are made.

10. If you do have any questions about your situation, you are encouraged to contact a representative of your local FACMT. If legal questions arise you are encouraged to contact your local Staff Judge Advocate.

_____
(NAME)

_____
(GRADE)

_____
(TITLE)

_____
(FACILITY)

I acknowledge receipt of written notification that my child _____ is being evaluated for possible abuse or child neglect. The contents of this letter and its possible implications have been explained to me. I have been provided the telephone numbers of a FACMT representative and the local Staff Judge Advocate.

_____
(NAME)

_____
(RELATIONSHIP)

_____
(DATE)

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: CHILD ABUSE AND NEGLECT PHYSICAL EXAM *(For use of this form see MEDCOM Pam 608-1)*	OTSG APPROVED *(Date)*

I. PATIENT IDENTIFICATION DATA

1. Patient's Name *(Last, First, MI)*:

2. Patients Date Of Birth:	Sex: MALE ☐ FEMALE ☐

3. Patient's Home Address:	Phone Number:

4. Sponsor's Name:	Marital Status:

5. Sponsor's Social Security Number:

6. Sponsor's Rank/Branch of Service:

7. Sponsor's Military Organization *(Unit)*:

8. Sponsor's Home Address:

9. Spouse's Name:

10. Spouse's Social Security Number:

11. On Post Housing: YES ☐ NO ☐	12. Sponsor's Phone Number: Home:	Duty/Work:

13. Other Children/Adults Living in Home.

NAME	AGE

14. Type of Alleged Maltreatment:
PHYSICAL ☐ SEXUAL ☐ EMOTIONAL ☐ NEGLECT ☐

15. Date of Incident	Date Incident Reported	16. Who Brought Patient in for Examination:

17. Alleged Perpetrator *(Last, First, MI)*:

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*	☐ HISTORY/PHYSICAL ☐ FLOW CHART ☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify) ☐ DIAGNOSTIC STUDIES ☐ TREATMENT

DA FORM 1 MAY 78 4700 Replaces HSC Forms 511, 514, and 515 MEDCOM OP 6-R, (MCHO) Jul 95, (Page 1 of 12)

	II. PHYSICAL EXAMINATION *(Check the appropriate box and comment(s), including description)*
	1. GENERAL APPEARANCE
	a. Within normal limits:
	b. Clothes dirty or inappropriate for climate:
	c. Appears malnourished:
	d. Height: / %
	e. Weight: / %
	f. OFC: / %
	g. Evidence of limp/pain moving:
	h. Withdrawn:
	i. Poor Hygiene:
	j. Other/Comment:
	2. HEAD - GENERAL *(Diagram on page 6)*
	a. Within normal limits:
	b. Shape
	c. Absent hair patches:
	d. Bruises *(Describe age, number, pattern):*
	e. Abrasions:
	f. Lacerations:
	g. Palpable deformities or swelling
	h. Other/Comment:
	3. EARS *(Diagram on page 6)*
	a. Within normal limits:
	b. Hemotympanum:
	c. Ruptured tympanic membrane:
	d. Battles sign:
	e. Injury to pinna/cauliflower ear:
	f. Other/Comment:
	4. NOSE *(Diagram on page 6)*
	a. Within normal limits:
	b. Blood in nares:
	c. Displaced septum:
	d. Bruises/Abrasions
	e. Other/Comment:
	5. EYES *(Diagram on page 6)*
	a. Within normal limits:
	b. Scleral hemorrhage:
	c. Blue Sclera:
	d. Retinal hemorrhage/detachment:
	e. Displaced lens:
	f. Blood in anterior chamber:
	g. Pupils unequal/nonreactive:
	h. Black eyes:
	i. Abnormal EOM:
	j. Other/Comment:
	6. MOUTH/THROAT *(Diagram on page 6)*
	a. Within normal limits:
	b. Torn frenula:
	c. Lacerations - cheeks/lips/gums/tongue:
	d. Loose/broken teeth:
	e. Severe caries:

	6. MOUTH/THROAT (Cont) *(Diagram on page 6)*
	f. Mandibular tenderness, displacement, swelling:
	g. Hematoma inner cheeks:
	h. Other/Comment:
	7. FACE - GENERAL *(Diagram on page 6)*
	a. Within normal limits:
	b. External trauma (bruises, abrasions, burns, lacerations):
	c. Other/Comment:
	8. NECK *(Diagram on page 6)*
	a. Within normal limits:
	b. External Trauma (bruises, abrasions, burns, lacerations):
	c. Choking marks:
	d. Stiff neck:
	e. Other/Comment:
	9. CHEST *(Diagram on page 7)*
	a. Within normal limits:
	b. External Trauma (bruises, abrasions, burns, lacerations):
	c. Unequal breath sounds (hemothorx/penumothorax):
	d. Muffled heart tones (pericardial tampanade/effusion):
	e. Bruises/bite marks on breasts:
	f. Trauma to axillae:
	g. Evidence of rib tenderness/fractures, swelling, deformity:
	h. Other/Comment:
	10. ABDOMEN *(Diagram on page 7)*
	a. Within normal limits:
	b. External trauma (bruises, abrasions, burns, lacerations):
	c. Abdominal tenderness/rebound tenderness/masses:
	d. Protuberant abdomen of malnutrition (abdominal distention or protuberance):
	e. Guiac positive stools:
	f. Absent bowel sounds (Splenomegaly, hepatemegaly):
	g. Other/Comment:
	11. BACK *(Diagram on page 7)*
	a. Within normal limits:
	b. External trauma (bruises, abrasions, burns, lacerations):
	c. Spinal tenderness
	d. Costo vetebral tenderness:
	e. Splinting of back muscles (muscle spasm):
	f. Other/Comment:
	12. EXTREMITIES *(Diagram on page 8)*
	a. Within normal limits:
	b. External trauma (bruises, abrasions, burns, lacerations):

	12. EXTREMITIES (Cont) *(Diagram on page 8)*
	c. Deformities (fractures/periosteal elevation):
	d. Joint Swelling:
	e. Limited range of motion of joint(s):
	f. Localized tenderness:
	g. Other/Comment:

	13. NEUROLOGIC
	a. Within normal limits:
	b. Focal neurologic signs:
	c. Cranial nerve dysfunction:
	d. Nonresponsiveness to pain:
	e. Mental Status:
	f. Cranial nerves:
	g. Reflexes:
	h. Motor strength:
	i. Coordination:
	j. Sensory system:
	k. Cerebellar functions:
	l. Other/Comment:

14. SKIN *(Use diagrams on pages 7 & 8)*

Describe bruises, abrasions, burns, lacerations *(i.e., location, age, number, pattern...etc.)*:

15. LABORATORY

Yes	No	REQUESTED
		a. PTT:
		b. PT:
		c. Platelets:
		d. CBC:
		e. Other:

16. X-RAYS *(Use diagrams on page 9 & 10)*		
Yes	No	REQUESTED
		a. Long Bones:
		b. Skull:
		c. Ribs:
		d. Other:

Yes	No	17. BONE SCAN *(Use diagrams on page 9 & 10)*

18. PHOTOGRAPHS TAKEN BY:

19. REFERRAL TO CHILD PROTECTIVE SERVICES MADE BY:

III. GENITAL/ANAL EXAM FOR SUSPECTED SEXUAL ABUSE *(Check the appropriate area) (Use diagram on page 11)*

Define genital examination techniques in the space provided below:

** NOTE: The use of a colposcope is restricted to only those pediatricians/physicians who have been fully trained in the use of this instrument on children who have been sexually abused.

	LABIA	INTROITUS	VAGINA	CERVIX	PERINEUM	ANUS	PENIS	SCROTUM
a. Within normal limits								
b. Not examined								
c. Bruises/Bites								
d. Redness								
e. Swelling								
f. Abrasions								
g. Lacerations								
h. Blood								
i. Discharge								
j. Scars								
k. Burns								
l. Giac positive stool								
m. Foreign bodies								

n. Other (Describe):

Approximate size of hymenal opening:

Type of measurement: ☐ Visual estimate ☐ Tape measure

☐ Other (Describe):

Anal Tone: ☐ Normal ☐ Lax ☐ Spasm

☐ Other (Describe):

Tanner stages of sexual maturity:

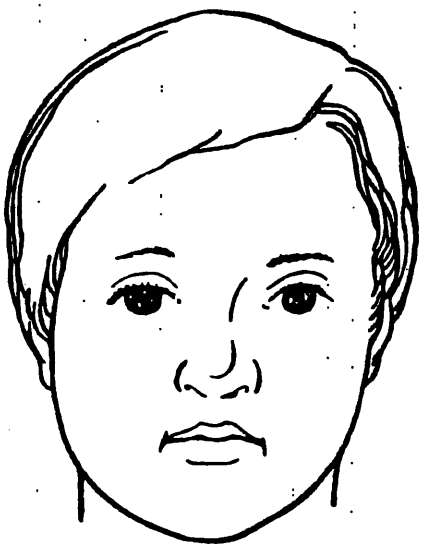
Breast: _____ Pubic Hair: _____ Penis/testes: _____

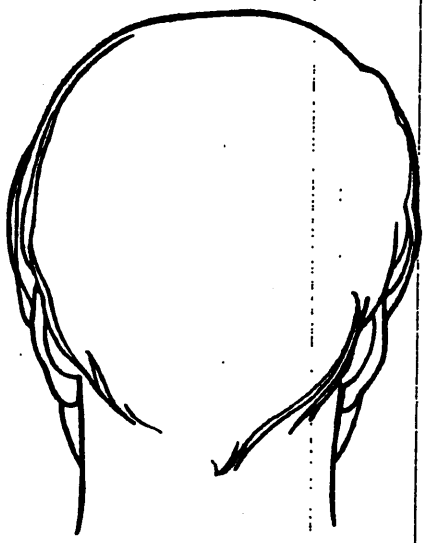
Colposcope used for visual exam: ☐ Yes ☐ No | Colposcope photographs taken: ☐ Yes ☐ No

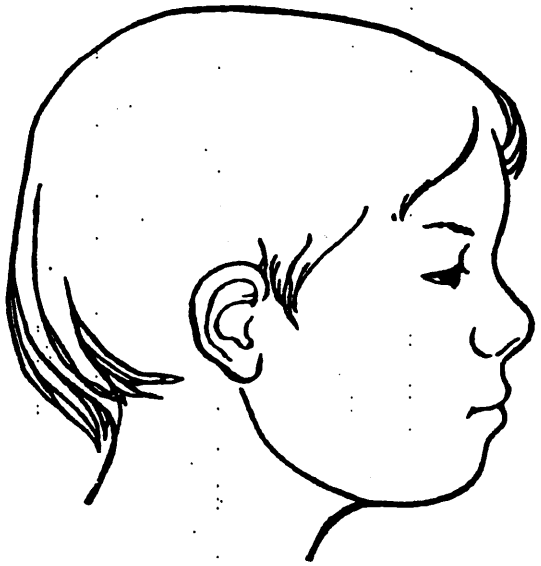
MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

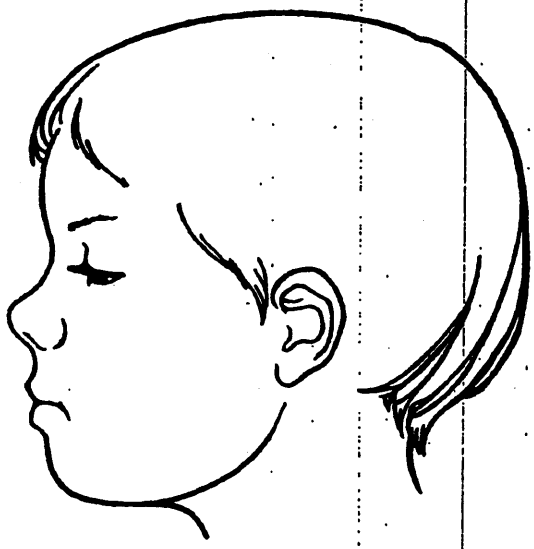
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)*









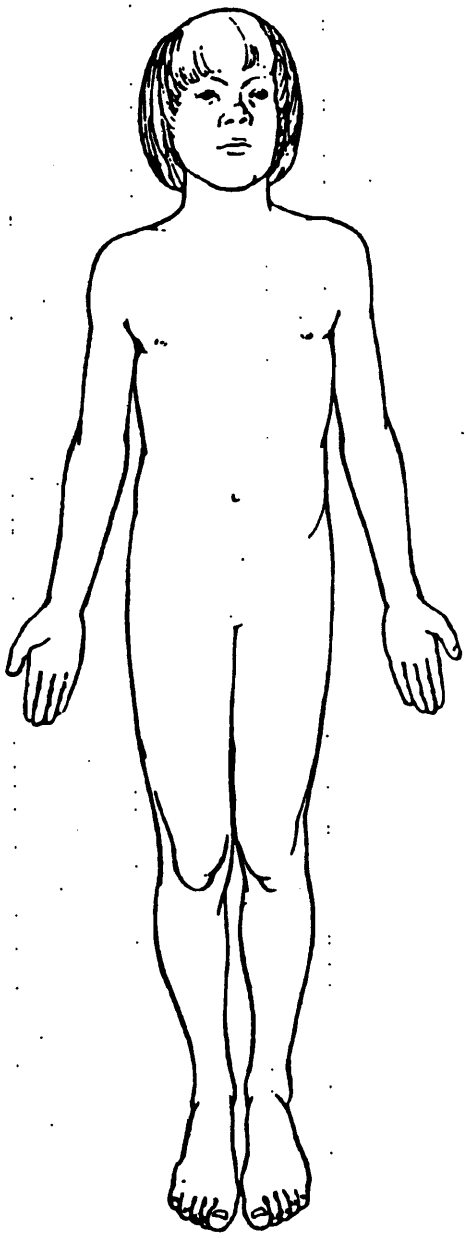
PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

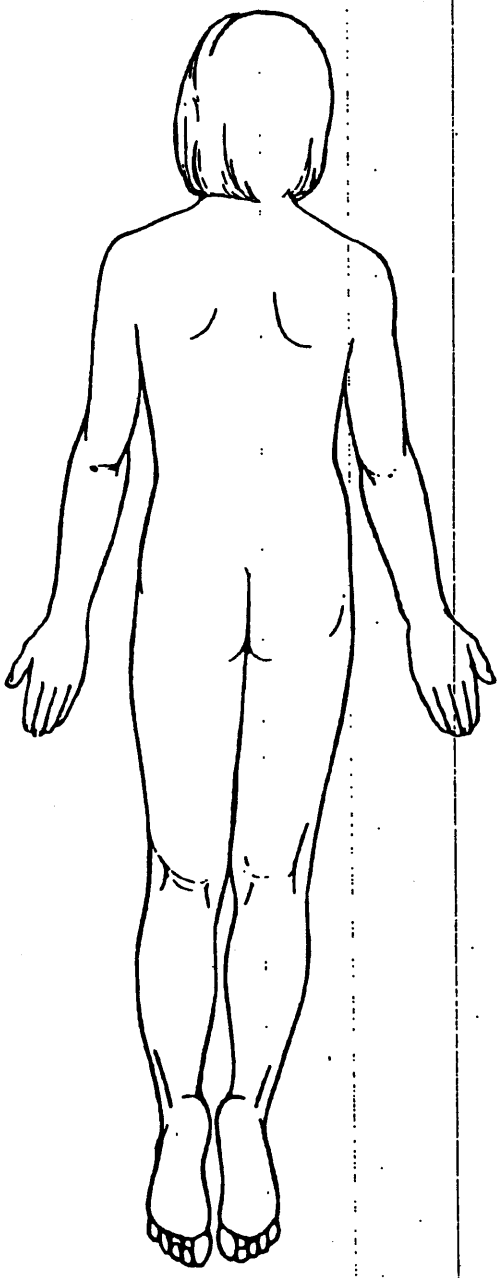
PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*	☐ HISTORY/PHYSICAL ☐ OTHER EXAMINATION OR EVALUATION ☐ DIAGNOSTIC STUDIES ☐ TREATMENT	☐ FLOW CHART ☐ OTHER (Specify)

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)*





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- ☐ TREATMENT

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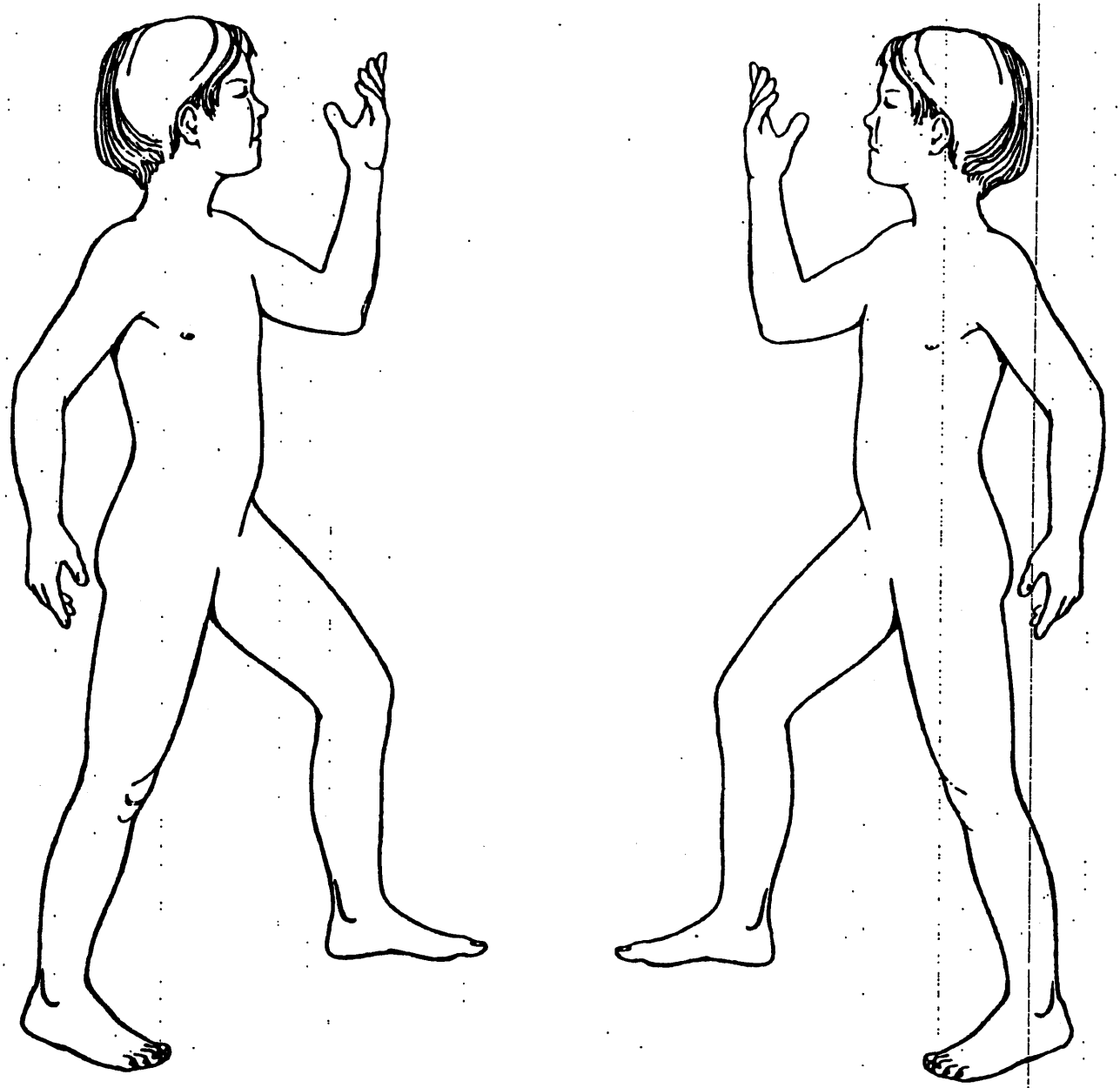
MEDCOM OP 6-R, (MCHO) Jul 95, (Page 7 of 12)

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)*



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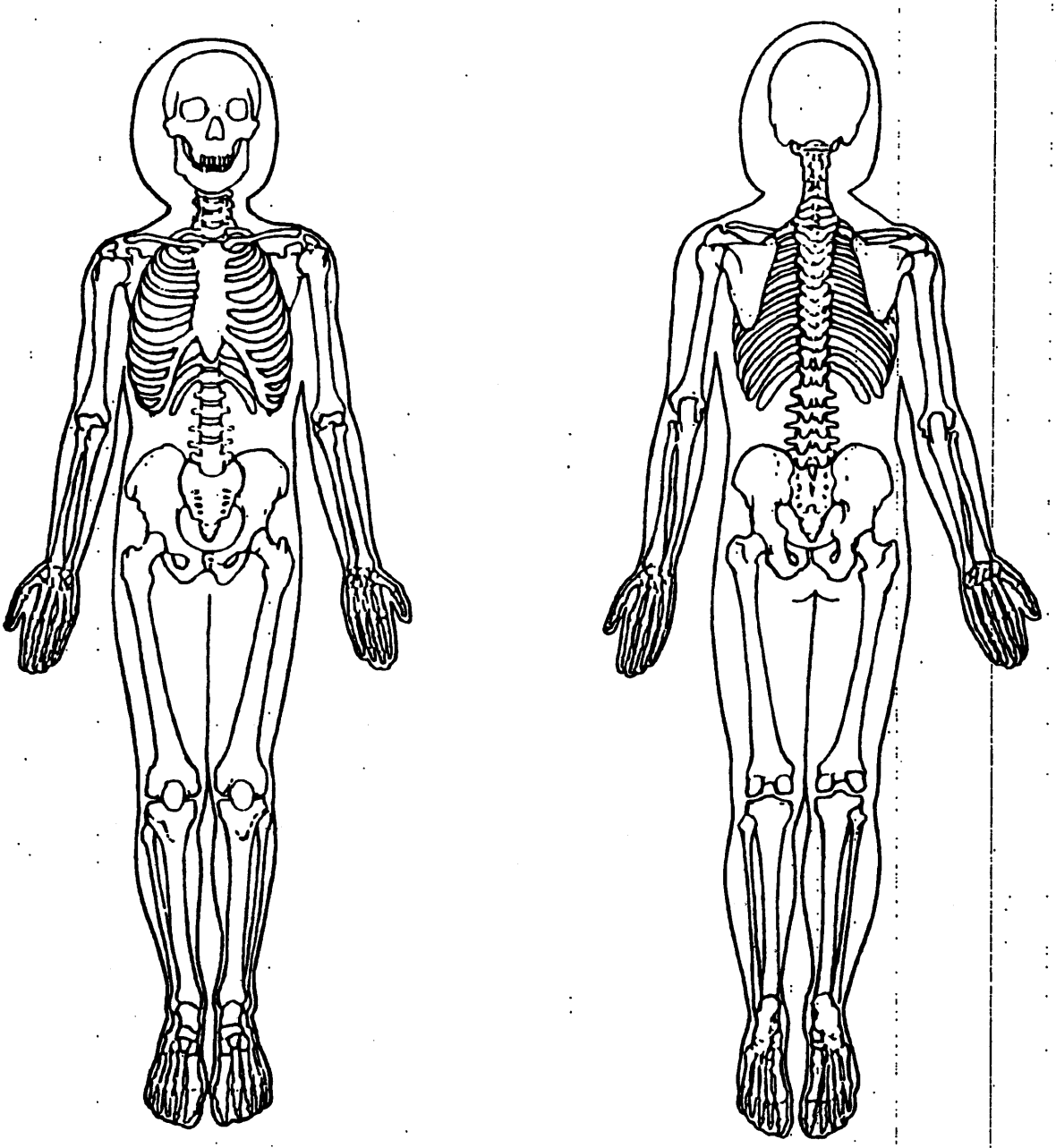
REPORT TITLE	OTSG APPROVED *(Date)*



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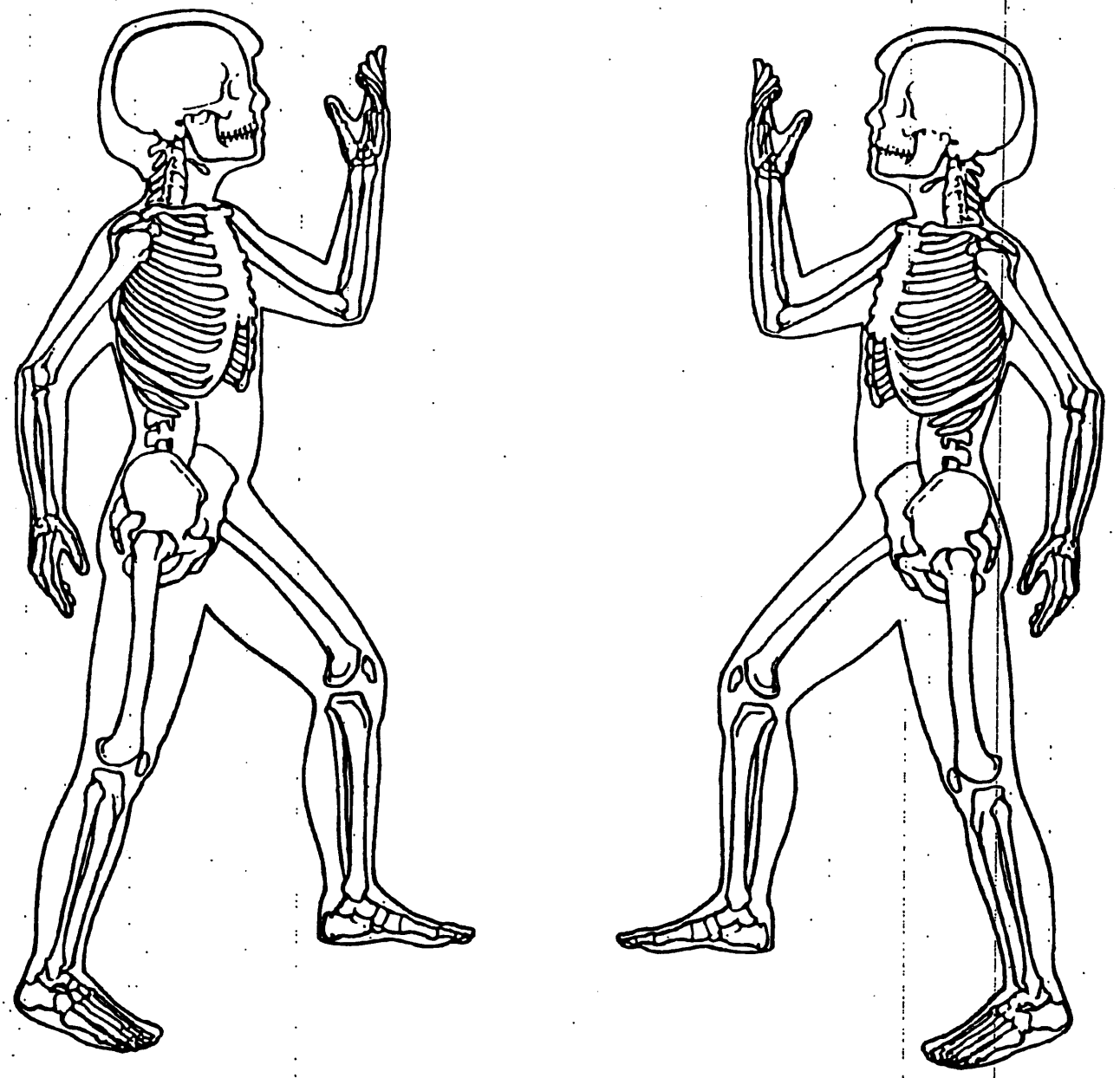

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MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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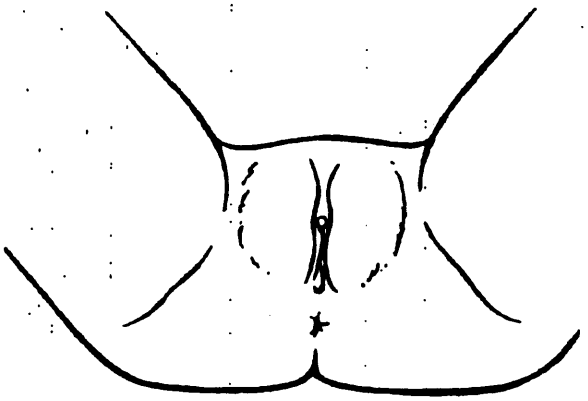

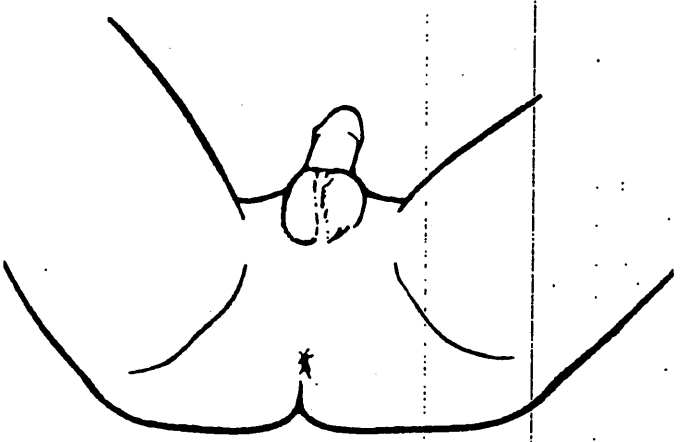

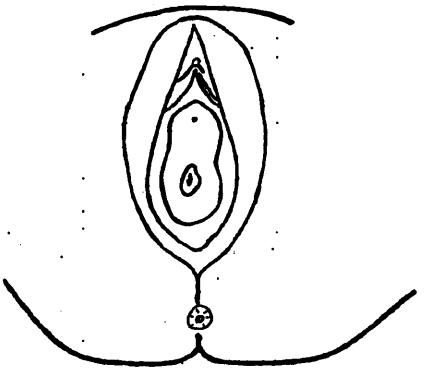

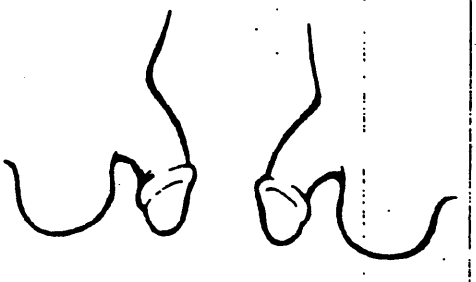

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- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

IV. HISTORY AND IMPRESSIONS

(Include HP, past medical history, family history, social history, and impressions)

Child Abuse/Neglect Risk Assessment

For use of this form see MEDCOM Pam 608-1

RISK FACTORS	LOW (L)	MODERATE (M)	HIGH (H)	CODE
Severity of abuse	No medical treatment needed	Minor physical injury/treatment*	Major physical injury/hospital-ization*	
Timeliness of seeking medical care	Immediate	Delayed	Significantly delayed	
History of abuse/FAP history	No prior reports or injuries	Prior minor injuries*	Subsequent incidents with major injuries*	
Protection of child	Caretaker will protect children	Questions need to protect children	Will not protect children	
Fear of returning home	None	Some	Significant	
Sexual abuse	No evidence or allegation	Allegation with no evidence	Evidence of sexual abuse*	
Stress factors	None	Minimal	Multiple	
Evidence of neglect	None	Non-life threatening	Life threatening*	
Age	12 +	4 - 11	0 - 3	
Caretaker coping skills	Excellent	Adequate	Poor	
Caretaker substance use	None	Some use, non-contributing factor	Significant use, contributing factor	
Develop-mental & behavioral problems of the child	None	Documented but non-contributing	Documented and contributing	

COMMENTS: _____

DATE: _____

PT NAME: _____

SSN: _____

WORKER: _____

RECOMMENDATIONS:

INSTRUCTIONS

1. Use of this form in instances of child abuse/neglect assessment, and consultation with other professionals, will aid the interviewer in determining the immediate safety of the victim. This determination should be the basis for developing plans and options for the victim and any other children in the household. The safety of the child should always be the prime consideration. The Command must always be notified.

2. In making a determination and plans, consider the following:

a. Any "H" rating must be thoroughly evaluated to determine whether or not the child may be safely returned to the caretaker. If the child can not be returned to the caretaker, other appropriate options (foster care, shelter, confinement of the perpetrator) must be considered.

b. A majority of "M" ratings require additional assessment prior to making a disposition.

c. A majority of "L" ratings indicate there is little or no risk of maltreatment.

d. Items indicated by an "*" are defined in AR 608-18 and local SOPs.

3. Use the 'Comments' section to include the additional information that contributed to making a determination of risk.

4. Discuss any questions of interpretation of the Risk Assessment tool with the Chief Social Work Service, or immediate supervisor.

APPENDIX C

MEDICAL PROTECTIVE CUSTODY OF CHILD

(Date)_____

I have determined there exists a reasonable belief that _____
Is in imminent danger of harm and should be placed on Medical Protective Custody IAW AR 608-18, PARA 3-23. The medical evidence, which supports my belief, is Summarized as follows:

1. Patient's name and Parent's/Sponsor's address (include county).

2. Name and address.

3. Findings.

4. Parental consent for appropriate medical care cannot be obtained.

5. Recommendations: Child should be placed in Medical Protective Custody.

_____
(Signature of Treating Physician)

Recommendation is: ( ) Approved ( ) Disapproved

_____
(Signature of WRHCS Commander)

DISTRIBUTION:
Parents of Patient
Unit Commander of Military Parent(s)
CRC Chairperson
Provost Marshal
Child Protective Services (county of patient's residence)

WRAMC FORM 1376
16 OCT 01

Appendix D

Physician Protocol for Evaluation of Spouse/Elder or Dependent Adult Abuse/Neglect

PROCEDURES:

Spouse Abuse/Neglect:

1. Report all suspected maltreatment to the WRAMC Department of Social Work (DSW). The DSW will report to the appropriate county Adult Protective Service unit and the WRAMC Provost Marshall (782-7511/12). The DSW can be reached:

a. At 782-6378 during duty hours (0730-1630).

b. After duty hours, weekends and holidays, through the Administrative Officer of the Day (AOD) at 782-7309. The AOD will page the on-call social worker.

2. Coordinate conducting the medical evaluation with the WRAMC Social Worker involved in the case as necessary. Jointly decide how to handle hostile or volatile caretakers or suspected perpetrators. The Provost Marshall's are available to assist with difficult situations.

3. Obtain a detailed history of the injury from the victim. If the suspected perpetrator is present, separate the victim from the suspected perpetrator prior to questioning the victim. DO NOT question the suspected perpetrator unless he/she is the only source of necessary information (i.e., the victim is unconscious, etc.). The questioning of suspected perpetrators is a police function and requires the interviewer to read rights.

4. Prepare the victim for the emotional aspects of the physical examination, especially in cases of alleged sexual abuse/rape.

5. Perform a thorough physical examination. Photograph visible finding with color film (if the victim gives consent):

a. Ask the photographer to bring Form 28, Medical Illustration Service Request and Release. The physician must fill out Form 28. Patient consent is required. The photographer can be reached at 782-7074 during duty hours. After duty hours, call (202) 991-4535, after the ring and tone, dial call back number OR call the AOD who will contact the photographer.

b. Record all physical findings using the Spouse Abuse/Neglect Physical Exam form, MEDCOM OP 33-R, (MCHO) Apr 95.

6. Record how soon medical care was sought after the injury was discovered; comment on whether explanations of the injury are consistent, whether explanation of the injury is plausible, and whether findings are consistent or inconsistent with type of alleged maltreatment. **Do Not record the opinion that abuse/neglect definitively did or did not occur.**

Appendix D (Continued)

7. Coordinate with the DSW to determine the risk to the victim should he/she return home. If the victim remains at risk - based on the Risk Assessment (completed by the Social Worker) and the professional opinion of the treating physician – alternate temporary living arrangements should be negotiated (with the victim's cooperation).

8. Elder or Dependent Adult Abuse/Neglect

a. Categories of Elder or Dependent Adult Abuse/Neglect.

(1) Physical abuse: The non-accidental use of physical force that result in bodily injury, pain or impairment.

(2) Sexual abuse: Non-consensual sexual contact of any kind.

(3) Emotional or Psychological Abuse: The willful infliction of mental or emotional anguish by threat, humiliation, intimidation, or other verbal or non-verbal abusive contact.

(4) Neglect: The willful or non-willful failure by the caregiver to fulfill his/her care-taking obligation or duty.

(5) Exploitation: The unlawful appropriation or use of another's money or material wealth for one's own benefit or that of a third person.

(6) Self-Abuse/Neglect: The abusive or neglectful conduct of an adult directed at self that threatens his/her health or safety.

b. Procedures for evaluation of elder or dependent abuse/ neglect are the same as for procedures for evaluation of spouse abuse in paragraphs 1 through 7 above. Where the word "spouse" appears, line it out and initial it.

c. Unlike cases of child abuse, competent elderly or dependent adult patients can choose to return to the family despite the suspicion. Also, a competent elderly or dependent adult patient can refuse medical or social work/social service intervention and has the right to privacy.

d. Should the patient refuse medical care and return home, the social worker will make an immediate referral to Adult Protective Services in the county where the patient resides.

e. The social worker must also inform patients of their rights and potential entitlements under Public Law 101-647, Sec 401, also known as the Victim and Witness Assistance Program.

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE	OTSG APPROVED *(Date)*
SPOUSE ABUSE CHECKLIST *For use of this overprint see MEDCOM Pam 608-1.*	

PART 1: MEDICAL HISTORY AND PHYSICAL EXAMINATION

NOTE: It is important to fully examine the patient and document the results clearly and concisely.

A. PATIENT'S CHIEF COMPLAINT

B. TIME, DATE, AND LOCATION OF INCIDENT

C. NAME AND RELATIONSHIP OF INDIVIDUALS WHO ACCOMPANIED PATIENT ON THIS VISIT

D. NAME AND RELATIONSHIP OF ALLEGED PERPETRATOR

	YES	NO
E. DO THE PATIENT AND ALLEGED PERPETRATOR LIVE TOGETHER?		
F. SUSPECTED SUBSTANCE USE/ABUSE? (If yes, identify):		
G. IS THE PATIENT TAKING ANY MEDICATIONS? (If yes, identify):		
H. ALERGIC TO ANY MEDICATIONS? (If yes, identify):		
I. TOXICOLOGY SCREENS COMPLETED, AS CLINICALLY INDICATED? (If yes, identify):		
J. IS THE PATIENT PREGNANT?		
K. PREGNANCY TEST OFFERED?		
L. PREGNANCY TEST CONDUCTED?		
M. WAS THE PATIENT A VICTIM OF RAPE, SEXUAL ASSAULT, OR NON-CONSENTING SEXUAL CONTACT? (If yes, identify):		
N. MTF COMMANDER NOTIFIED OF SEXUAL ASSAULT?		
O. STD SCREEN OFFERED?		
P. STD SCREEN CONDUCTED?		
Q. HIV SCREEN OFFERED?		
R. HIV SCREEN CONDUCTED?		
S. WAS THE PATIENT'S LIFE OR SAFETY THREATENED?		

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

	YES	NO
T. WAS ANY WEAPON USED IN THE MALTREATMENT? (If yes, identify):		
U. ANY CURRENT INJURIES? (If yes, identify):		
V. INJURIES DOCUMENTED ON ENCLOSED DIAGRAMS?		
W. PHOTOGRAPHS TAKEN?		
X. IS PATIENT SUICIDAL OR HOMICIDAL? (If yes, indicate which and consult Psychiatry):		
Y. SOCIAL WORK SERVICE NOTIFIED?		
Z. MILITARY POLICE OR LOCAL POLICE NOTIFIED? (If yes, who?):		
AA. SPOUSE ABUSE AND SHELTER INFORMATION OFFERED?		
BB. DOES PATIENT FEEL SAFE TO RETURN HOME?		
CC. HAVE ARRANGEMENTS BEEN MADE FOR THE SAFETY OF THE CHILDREN?		
DD. IS THE LOCATION OF THE ALLEGED PERPETRATOR KNOWN?		
EE. HAS THE PATIENT BEEN INFORMED THAT THE SITUATION IS POTENTIALLY LETHAL AND THAT OTHER ALTERNATIVES ARE AVAILABLE TO HER/HIM?		
FF. OTHER (Specify)		

PART 2: SOCIAL WORK ASSESSMENT

The on call social worker will conduct a brief social work assessment of the patient to include the following.

A. EXPLANATION OF THE CURRENT INCIDENT:

B. HISTORY OF RECENT SPOUSE ABUSE:

C. RISK ASSESSMENT:

D. SAFETY PLAN (To include support systems):

E. DIAGNOSTIC IMPRESSION(S):

F. SPONSOR'S COMMAND INFORMED? ☐ YES ☐ NO

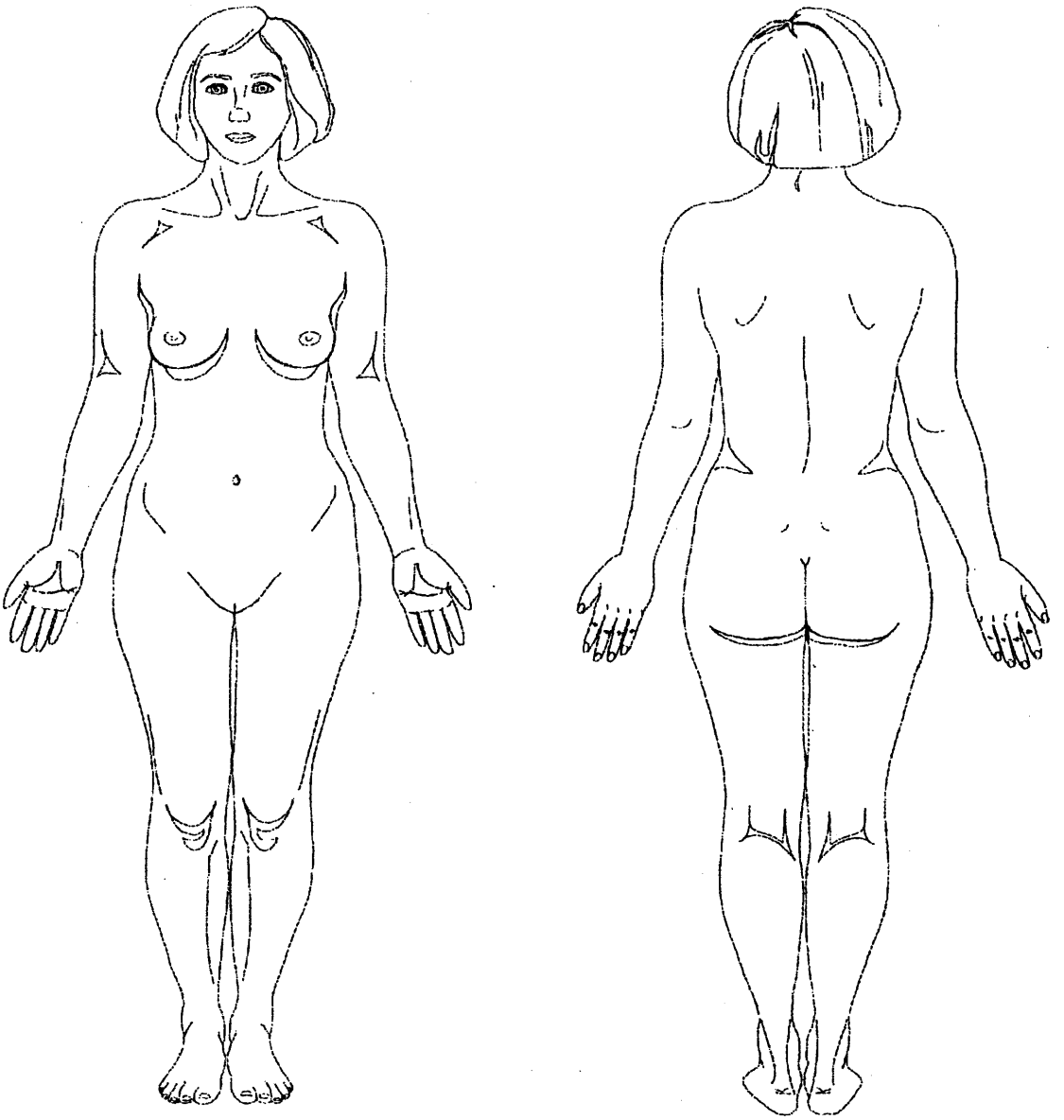
G. REFERRAL AND FOLLOW-UP SERVICES SCHEDULED? ☐ YES ☐ NO

MEDCOM OP 33-R (MCHO-CL) APR 95 (Back)

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE:	**SPOUSE ABUSE PHYSICAL EXAMINATION DIAGRAM - FEMALE** For use of this form see MEDCOM Pam 608-1	OTSG APPROVED *(Date)*



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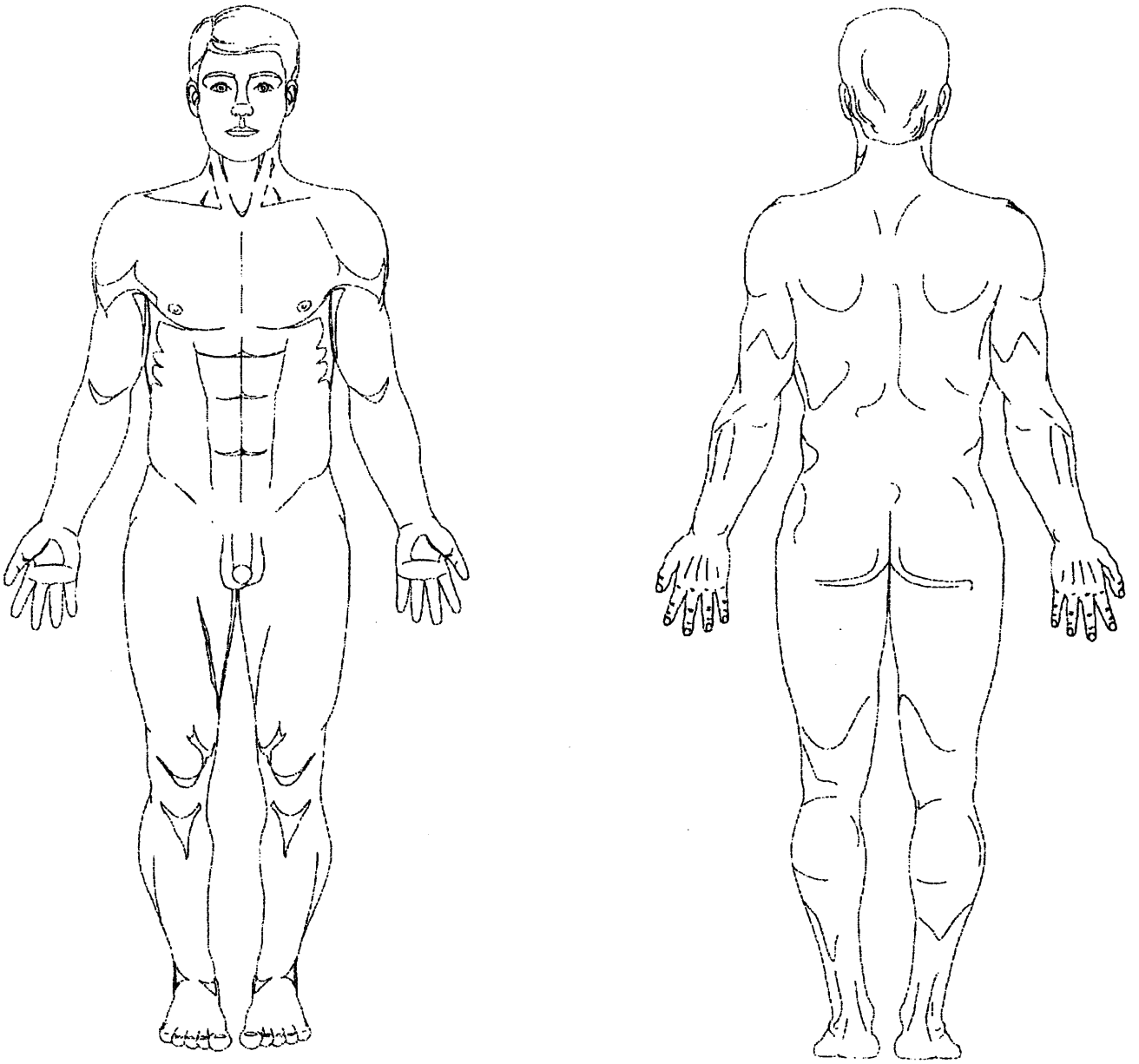
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 1 MAY 78 4700 **MEDCOM OP 28A-R (MCHO), Feb 95** PREVIOUS EDITIONS OF THIS OVERPRINT ARE OBSOLETE MC V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE:	SPOUSE ABUSE PHYSICAL EXAMINATION DIAGRAM - MALE For use of this form see MEDCOM Pam 608-1	OTSG APPROVED *(Date)*



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PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

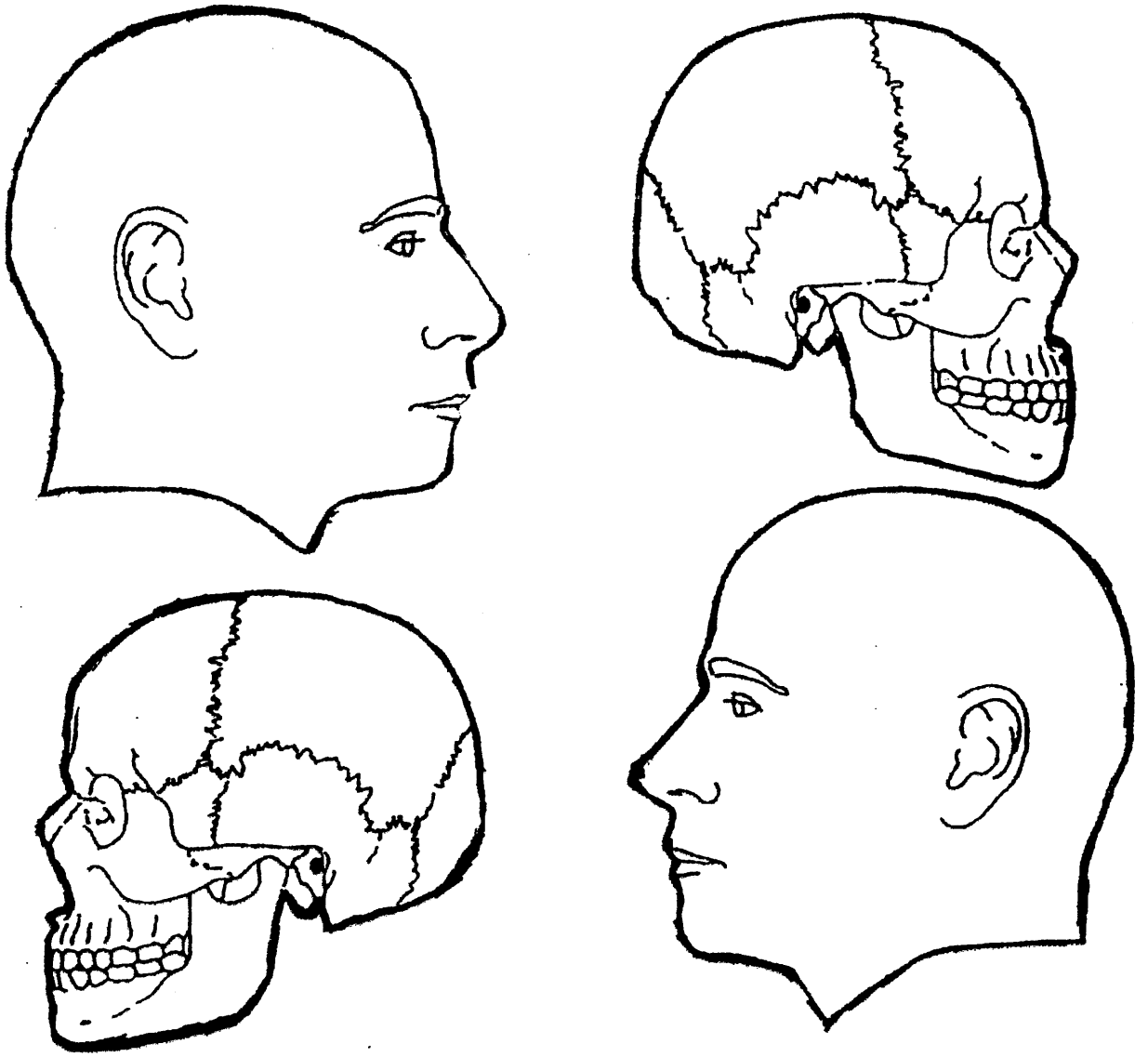
- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 1 MAY 78 4700 **MEDCOM OP 28B-R (MCHO), Feb 95** PREVIOUS EDITIONS OF THIS OVERPRINT ARE OBSOLETE MC V1.00

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE:	OTSG APPROVED *(Date)*
SPOUSE ABUSE PHYSICAL EXAMINATION DIAGRAM - HEAD, SURFACE, AND SKELETAL ANATOMY For use of this form see MEDCOM Pam 608-1	



(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

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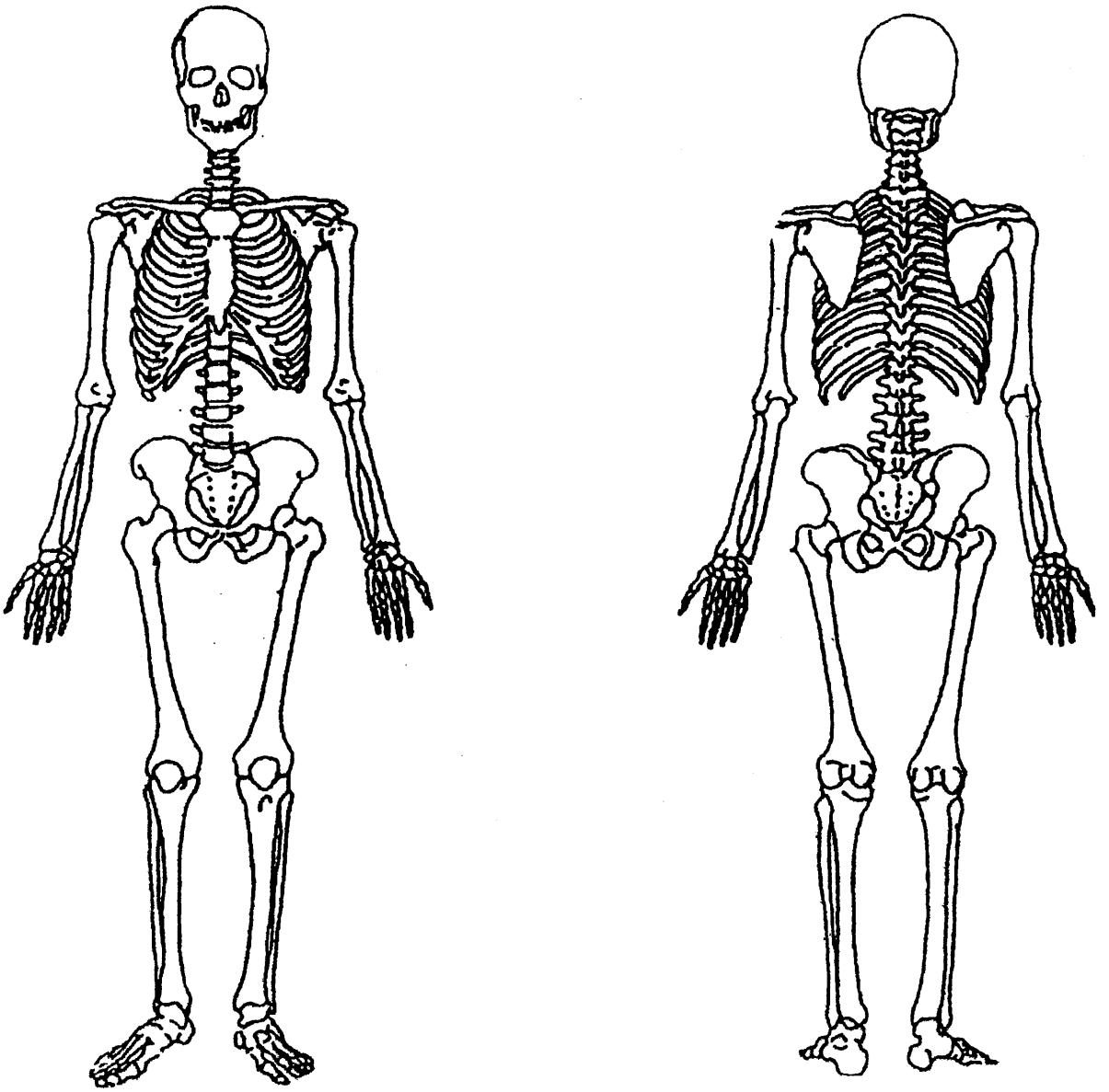
MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE:	**SPOUSE ABUSE EXAMINATION DIAGRAM - SKELETON** For use of this form see MEDCOM Pam 608-1	OTSG APPROVED *(Date)*



(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

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Spouse Abuse Risk Assessment

For use of this form see MEDCOM Pam 608-1

RISK FACTORS	LOW (L)	MODERATE (M)	HIGH (H)	CODE
History of Abuse/FAP history	No prior reports or injuries	Prior minor injuries*	Subsequent incident with major injuries*	
Substance use	None	Some use, non-contributing factor	Significant use, contributing factor	
Extent of physical injury	No medical treatment needed	Minor physical injury/treatment*	Major physical injury* or hospitalization. Injury during pregnancy	
Use of weapons	None	Weapons available, not used	Weapon used or threat to use	
Emotional maltreatment	None/infrequent	Frequent/chronic	Threats of death or serious injury/stalking	
Location of children	Known/no risk	Known, minimal risk	Unknown or with perpetrator	
Forced sex	No evidence or allegation	Allegation with no evidence	Evidence of forced sex	
Family stressors	None	Minimal	Multiple	
Location of perpetrator	Known, no access to victim	Known, access to victim	Unknown or "Atlarge"	
Assault history of perpetrator	None	Infrequent/ occasional episodes	Frequent/chronic episodes	
Fear of perpetrator	None	Minimal	Significant	
Safety plan	Appropriate	Vague	None	

COMMENTS: _____

_____

_____

_____

_____

_____

DATE: _____

PT NAME: _____

SSN: _____

WORKER: _____

_____

RECOMMENDATIONS:

This form has been reviewed by me and I understand the risks and recommendations

SIGNATURE: _____ DATE: _____

INSTRUCTIONS

1. Use of this form in instances of spouse abuse assessment and consultation with other professionals, will aid the interviewer in determining the immediate safety of the victims. This determination should be the basis of developing plans and options for the victim and any dependent. The safety of the spouse and any children should always be the prime consideration. The Command must always be notified.

2. In making a determination and plans, consider the following:

a. Any "H" rating must be thoroughly evaluated to determine whether or not the spouse may safely return home. If the spouse can not return home, other appropriate options (e.g., shelter, confinement of the alleged perpetrator, etc.) must be considered.

b. A majority of "M" ratings require additional assessment prior to making a disposition.

c. A majority of "L" ratings indicate there is little or no risk of maltreatment.

d. Regardless of the determined level of risk (coding), a nonmilitary victim has the legal right to refuse any recommendations.

e. Advise the victim of the determined risk and recommendations. The victim needs to indicate by their signature that they have been advised of the risks and treatment recommendations.

f. Items indicated by an "*" are defined in AR 608-18 and local SOPs.

3. Use the 'Comments' section to include additional information that contributed to making a determination of risk.

4. Discuss any questions of interpretation of this Risk Assessment tool with the Chief, Social Work Service or immediate supervisor.

GLOSSARY

Section I
Abbreviations

ACS ..... Army Community Service

CHCS ..... Composite Health Care System

CID ..... Criminal Investigation Division

DEOM ..... Department of Emergency and Operational Medicine

DSS ..... Department of Social Services

DSW ..... Department of Social Work

FAP ..... Family Advocacy Program

MEDCEN ..... Medical Center

MOD ..... Medical Officer of the Day

MTF ..... Military Treatment Facility

PCAN ..... Protocol for Child Abuse and Neglect

RPOC ..... Reporting Point of Contact

Section II
Terms

Child Maltreatment. The physical injury, sexual abuse, emotional abuse, deprivation of necessities, or other maltreatment of a child by a parent, guardian, or any other person (including an employee of a residential facility or any staff person providing out-of-home care) who is responsible for the child's welfare on a temporary or permanent basis.

Child Physical Abuse. Child physical abuse refers to physical acts that caused or may have caused physical injury to the victim or physical injuries that seriously impair the health or physical well being of the victim.

Child Sexual Abuse. A category of abusive behavior within the definition of child abuse that includes the rape, molestation, prostitution, or other such form of sexual exploitation of a child, or incest with a child, or the employment, use, persuasion, inducement, enticement, or coercion of a child to engage in, or assist in any sexually explicit conduct (or any simulation of such conduct) for sexual gratification or profit.

Child Neglect. Failure of a parent or caretaker to provide for a child's basic needs for food, clothing, shelter or medical care.

Elder Abuse. Elder abuse includes all suspicions of physical and psychological abuse, neglect and exploitation of vulnerable adults by a relative, guardian, or any other person who shares a dwelling with the victim or is responsible for the victim on a temporary or permanent basis. This is normally an individual over the age of sixty-five.

Emotional Abuse. Emotional abuse and neglect refers to a pattern of active, intentional berating, disparaging or other abusive or neglectful behavior toward the victim that may not cause observable injury. This definition can apply to child, spouse and elder or dependent adults.

Spouse Abuse. An assault, a battery, a threat to injure or kill, any other unlawful act of force or violence, or emotional maltreatment inflicted by one spouse in a marriage against the other regardless of age. Emotional maltreatment is conduct that, although not criminal, is so offensive to the victimized spouse that a reasonable person would find such conduct abhorrent
within a marital relationship.

The proponent agency of this publication is the Department of Social Work. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended changes to Publications and Blank Forms) to the Commander, Walter Reed Army Medical Center, ATTN: MCHL-SW, Washington, DC 20307-5001.

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